epiTRENDS

A Monthly Bulletin on Epidemiology & Public Health Practice in Washington State

Vol. 1 No. 4

Unintended Pregnancies: A Major Public Health Problem with Serious, Long-term Consequences for Society

Fifty-seven percent of all pregnancies and 44% of all births in the United States are unintended in that they are identified by the mother as either unwanted or mistimed at conception. Unintended pregnancy is not just a problem of teenagers or of unmarried, poor, or minority women. It is a problem that affects all segments of society. Unintended pregnancies can have serious consequences. They are associated with late or inadequate prenatal care, low birth weight, neonatal death, poor child health and development, domestic violence, child neglect and abuse, and exposure of the fetus to alcohol, tobacco, and other harmful substances. Unintended pregnancy clearly is a common denominator of many of today's health and human service problems.

After a decline during the 1970s, the percentage of U.S. births resulting from unintended pregnancies began increasing in the 1980s and continues to rise into the 1990s. According to a 1995 Institute of Medicine (IOM) report, unintended pregnancies occur in all groups of women, although the rates are higher for those who are young, poor, or minimally educated.

Trends in Washington State are similar to those seen nationally. Washington began tracking unintended pregnancy in 1993 through the Pregnancy Risk Assessment Monitoring System (PRAMS). This population-based survey sponsored by the Centers for Disease Control and Prevention is designed to supplement vital records with information on selected prenatal and peri-natal maternal behaviors. Because PRAMS collects information from pregnancies ending in live births, it can only be used to examine the prevalence of unintended births and will underestimate the prevalence of unintended pregnancies.

PRAMS data from 1993 and 1994 show that 40% of births in Washington were unintended at the time of conception. Table 1 (page 2) presents the proportion of unintended pregnancies among women of different age groups and education and income levels. Although women under age 20 had the highest proportion (68%), the highest number occurred among 20–29 year olds because this age group has the highest number of pregnancies. Most mothers (62%) who had births resulting from unintended pregnancies were not using birth control at the time they conceived. The remainder were the result of contraceptive failures. The women surveyed gave the following among reasons for not using birth control: side effects from contraception (19%), dislike of birth control (16%), lack of partner support for using contraception (19%), and did not expect to have sex (14%). Half of all unintended pregnancies end in abortion.

Year 2000 Goals and Strategies

One of the national Year 2000 goals advocated by the U.S. Public Health Service is to reduce the percentage of all unintended pregnancies to 30%, a goal already achieved in other industrialized nations where contraceptives are more readily available at lower cost. Although Washington is ahead of many other states, we will need to make significant efforts to attain the 30% goal. Doing so could significantly reduce state expenditures for prenatal and obstetrical care. In

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The Health of Washington State:

An Assessment of Health Status, Health Risks, and the Health System

This first statewide assessment is now available from the Department of Health. Call 360-753-5871.

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Pregnancy (from page 1)

1994 state funds paid for 40% of births at a cost of nearly $147 million.

The 1995 IOM report recommended strategies to reduce unintended pregnancy: (1) improve knowledge about contraception and reproductive health, (2) increase access to contraception, (3) address the roles of feelings, attitudes, and motivation in contraception and avoiding unintended pregnancy, (4) evaluate results of local programs, and (5) stimulate research.

"The IOM report helps local communities move beyond teen pregnancy to focus on the sexuality and reproductive health of all men and women," said Willa Fisher, chair of the Maternal and Child Health Advisory Committee of The National Association of County and City Health Officials and health officer for Bremerton/ Kitsap County. "NACCHO sees an important role for local health jurisdictions in increasing awareness of unintended pregnancy in their communities," Fisher added. NACCHO offers a publication giving practical action steps for local health agencies (see sidebar).

Assessment will assume an important role in confronting unintended pregnancy. Few programs to date have received adequate evaluation, except those aimed at adolescents. In this time of transition for traditional public health services, information on access, use, and payment for family planning services will become more crucial for statewide planning and policy making. Department of Health staff have begun to provide information and technical assistance to the State Board of Health, the Family Policy Council, the Public Health and Safety Networks, and other groups. DOH will cooperate more closely with local health jurisdictions, and other government agencies and groups (such as the Interagency Workgroup on Unintended Pregnancy) to address this problem. ◆

I believe the unifying agenda of all human service workers as we enter the 21st century ought to be the prevention of unintended pregnancy. The benefits are truly enormous.

Maxine D. Hayes, MD, MPH, Assistant Secretary, Washington State Department of Health

TABLE 1: Characteristics associated with unintended pregnancy, Washington State, 1993–94.

Characteristic	Proportion of Unintended Pregnancies (%)
Age (years)	
<20	68
20–24	56
25–29	34
30–34	22
35+	31
Education (years)	
<12	54
12	42
>12	33
Household Income Relative to Federal Poverty Level	
<100%	62
100–185%	54
>185%	29

Information Resources

Institute of Medicine: The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families. Washington, DC: National Academy Press, 1995.

Unintended Pregnancy: Prevention Strategies for Local Health Departments. Single copies are available free from NACCHO, 440 First St. NW, Suite 500, Washington, DC 20001, or call (202) 783-5550.

1995 Communicable Disease Report: A Few Significant Upward Trends

Reported cases declined between 1994 and 1995 for nine of the 14 infectious diseases listed in the surveillance table on page 3. The decreases ranged from 11% for hepatitis B and shigellosis to 49% for malaria. Reported cases increased for four diseases, including a dramatic 240% for measles and 250% for pertussis. Of particular interest are the trends for the following diseases.

Pertussis: The high rate recorded in 1995 (457 cases) continues in 1996. Reasons for the rising incidence include underimmunization of children and failure of physicians to recognize mild cases in adolescents and adults. Pertussis can infect even pre-viously immunized adults, who in turn infect children. Diagnostic tests should be considered for an atypical cough or one that lasts two weeks without other cause.

Meningococcal Disease: Severe infection with *Neisseria meningitidis* has been increasing over the past five years, perhaps due to a new strain identified in parts of Oregon and Washington. Asymptomatic carriers may transmit the organism, so prompt tracing of contacts is important.

Hepatitis B and Hepatitis C: Disease rates for these viral infections, both transmitted through body fluids, increased in 1995. Contract tracing and immunization are helping to reduce the incidence of hepatitis B. No vaccine or prophylactic intervention is available for Hepatitis C, which had the higher disease rate in 1995.

Annual Surveillance Data by County, 1995*

From the Annual Communicable Disease Report, Washington State Department of Health

County	Amebiasis	Campylobacteriosis	E. coli O157:H7	Giardia	Hepatitis A	Hepatitis B	Hepatitis Non-A, Non-B	Measles	Meningococcal Disease	Pertussis	Salmonellosis	Shigellosis	Acute PID	Chlamydia	AIDS
Adams	0	3	0	0	0	0	1	0	1	0	0	2	0	19	0
Asotin	1	3	1	7	0	0	0	0	0	0	2	1	0	40	1
Benton	1	4	1	8	5	4	6	0	4	1	22	5	19	159	3
Chelan	0	10	3	23	6	2	5	0	2	0	4	12	3	93	3
Clallam	1	7	0	6	11	4	2	0	1	1	3	0	8	60	2
Clark	2	71	9	67	79	29	29	0	18	18	27	8	81	467	24
Columbia	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0
Cowlitz	0	9	3	9	15	4	6	0	5	4	6	1	1	116	9
Douglas	0	2	0	4	5	1	0	0	2	1	1	3	0	45	0
Ferry	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Franklin	0	1	0	0	4	5	4	0	0	1	6	0	20	117	2
Garfield	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0
Grant	0	6	4	10	10	2	6	0	0	1	12	6	0	133	3
Grays Harbor	0	11	5	4	135	13	12	0	3	4	6	2	4	138	6
Island	0	7	1	3	8	1	1	0	1	2	5	1	0	81	6
Jefferson	0	6	0	11	4	3	1	1	1	1	2	0	0	16	1
King	35	311	42	258	151	73	5	6	25	273	264	158	135	3286	577
Kitsap	0	44	3	28	30	11	0	0	7	21	21	7	20	474	12
Kittitas	0	1	0	2	4	1	0	0	0	1	1	1	0	38	0
Klickitat	0	6	0	8	19	2	0	0	0	0	2	0	0	12	0
Lewis	0	21	8	4	14	2	0	0	3	3	4	5	6	68	1
Lincoln	0	0	1	1	0	0	0	0	0	0	3	0	0	7	1
Mason	0	4	0	6	9	3	9	0	0	4	3	0	5	52	11
Okanogan	0	2	3	4	4	0	1	0	0	0	1	5	0	55	1
Pacific	0	1	0	3	3	2	3	0	0	1	2	0	0	19	3
Pend Oreille	0	1	0	1	1	0	0	0	0	1	0	0	0	14	1
Pierce	1	72	6	37	165	26	11	0	6	47	53	23	82	1430	68
San Juan	0	0	0	1	0	0	0	0	0	2	0	0	0	5	1
Skagit	2	4	0	5	9	2	2	0	1	7	18	6	2	119	4
Skamania	3	1	0	1	1	2	2	0	0	0	0	0	0	2	0
Snohomish	0	122	16	80	25	15	8	0	4	37	47	46	19	656	59
Spokane	0	63	7	33	15	2	9	0	9	5	37	7	53	616	39
Stevens	0	2	0	0	0	0	0	0	2	0	2	1	4	28	1
Thurston	3	36	7	19	96	6	17	1	4	6	21	12	25	236	13
Wahkiakum	0	1	1	1	0	0	0	0	0	0	0	0	0	3	0
Walla Walla	0	14	1	2	5	4	2	0	6	0	6	5	2	122	7
Whatcom	0	45	10	33	7	1	0	9	4	29	26	7	4	198	16
Whitman	1	7	1	8	0	0	4	0	0	0	2	0	0	63	2
Yakima	10	152	7	166	97	6	88	0	17	20	82	102	5	465	13
1995 Total	60	1050	140	855	937	226	234	17	126	491	691	426	498	9462	890
1994 Total	78	1050	174	722	1119	255	294	5	111	140	863	478	615	10577	934
Percent Change	-23	0	-20	+18	-16	-11	-20	+240	+14	+250	-20	-11	-20	-11	-5

*The 1995 annual surveillance data is a special report for this issue. A copy of the full 1995 report can be obtained from:
Epidemiology, Washington State Department of Health, 1610 NE 150th, Seattle, WA98155-7224.
The monthly surveillance report will resume in the next issue of epiTRENDS.

Many Persons at High Risk for Influenza Are Not Vaccinated

A sure sign of fall is the proliferation of warnings about the approach of "flu season." Such warnings are important because many persons at increased risk for influenza are not vaccinated. A 1995 state survey indicated that only 28% of respondents had a flu shot during the previous 12 months. In the critical 65 and older age group only 66% reported that they had been vaccinated. The Advisory Committee on Immunization Practices recommends influenza vaccination for persons who meet any of the following criteria: aged 65 and older, residents of long-term care facilities, persons with chronic medical conditions or immune suppression, health care workers, and those with frequent contact with others who are at risk for influenza-related complications. Influenza vaccination may be considered for pregnant women who will be in the third trimester during the influenza season and for non high-risk persons who want to reduce the likelihood of acquiring influenza.

This year the Department of Health has included influenza vaccine as part of the state's childhood vaccine distribution program. Children and teenagers who fall into one of the influenza high-risk categories may receive state-supplied influenza vaccine. Please contact your local health department for more information.

The 1996–97 Influenza Vaccine Strains

The 1996–97 trivalent influenza vaccine includes A/Texas/36/91-like (H1N1), A/Wuhan/359/95-like (H3N2), and B/Beijing/184/93-like hemagglutinin antigens. U.S. influenza vaccine manufacturers will substitute the antigenically equivalent strains A/Nanjing/933/95 (H3N2) and B/Harbin/07/94 for the A/Wuhan/359/95-like and B/Beijing/184/93-like strains due to their superior growth properties. Clinicians should take note of these substitutions.

Recommendations Issued for Use of Immune Globulin

The recent licensure of hepatitis A vaccine and a continuing nationwide shortage of immune globulin (IG) for intramuscular injection has prompted the Centers for Disease Control and Prevention (CDC) and the Council of State and Territorial Epidemiologists (CSTE) to issue recommendations for the use of IG. In decreasing order of priority, IG should be used for:

- postexposure prophylaxis of persons who have had household or close personal contact (e.g., sexual contact) with a person with hepatitis A and for controlling outbreaks in day care centers; postexposure measles prophylaxis according to CDC guidelines; persons with immune deficiencies who are accustomed to using intramuscular IG;
- pre-exposure prophylaxis of children less than 2 years old who are traveling to areas of intermediate or high hepatitis A endemicity;
- pre-exposure prophylaxis of older children and adult travelers to areas of intermediate or high hepatitis A endemicity who have true contraindications (see package insert) to receiving hepatitis A vaccine;
- postexposure prophylaxis of persons exposed to food handled by a food handler with hepatitis A as defined by established criteria; and
- pre-exposure prophylaxis of travelers to areas of intermediate or high hepatitis A endemicity who are departing less than two weeks after hepatitis A vaccination.

Questions? Comments?

If you have a question about epidemiologic or public health issues, contact the editors at the address on the mailing panel or by email at function@u.washington.edu

epiTRENDS is published monthly by the Washington State Department of Health.

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